STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS NJ00158605, NJ00159562, NJ00160531, NJ00161286, NJ00162322, NJ00163614, NJ00164207, NJ00164446, NJ00164627, NJ00165469, NJ00168324, NJ00174057, NJ00174463, and NJ00174514 Survey Dates: 09/16/24 through 09/19/24. Census: 128 Sample Size: 37 A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH). The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 580	Continued From page 1	F 580		

treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and facility policy review, the facility failed to notify the resident's representative of a NJ Exec Order 26.4b1 in the resident's NJ Exec Order 26.4b1 for one of two residents (Resident (R) 224) reviewed for

Element #1
Resident #224 NJ ex order 26.4b1 NJ ex order 26.
On 9/20/2024, the US FOIA (B) (6) US FOIA (B) (6) re-educated all nurses

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F 580	Continued From page 2 NJ Exec Order 26.4b1 out of a total sample of 37. The facility failed to provide documentation that R224's representative was notified of a NJ ex order 26.4b1 NJ ex order 26.4b1 Findings include: Review of the facility's "Notification of Changes" policy, dated 11/2022 and 06/2023, revealed, ". . . The facility must inform the resident, consult with the resident's physician, and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances may be . . . Significant change in the resident's physical, mental or psychological condition such as deterioration in health, mental or psychosocial status . . ." Review of R224's "Face Sheet," provided by the facility, revealed an initial admission date of NJ ex order 26.4b1 and a readmission date of NJ ex order 26.4b1 with diagnoses of NJ ex order 26.4b1 Review of R224's 'NJ ex order 26.4b1 NJ ex order 26.4b1," located under the "Miscellaneous" tab of the EMR and dated NJ ex order 26.4b1, revealed the resident was NJ ex order 26.4b1 , an NJ ex order 26.4b1 NJ ex order 26.4b1. Review of R224's "Admit/Readmit Screener" form, dated NJ ex order 26.4b1 and completed when the resident NJ ex order 26.4b1, revealed the NJ ex order 26.4b1	F 580	on the policy on notification of change in condition. Element #2 All residents with changes in condition will have the potential to be affected by this alleged deficient practice. Element #3 All residents with changes in condition in the last 30 days from 9/20/2024 were reviewed by the Director of Nursing/designee to ensure notifications to the resident/resident representative/resident physician were made and documented, no issues were found during the review. All staff were re-educated by the ADON/designee on 9/23/2024, and ongoing, to ensure that the resident's medical records will reflect documentation that notifications were made to the resident/resident representative/resident physician when a resident experiences a change in condition. Any issues will be corrected immediately. Element #4 Licensed Nursing Home Administrator / designee will review 3 residents monthly for 6 months to determine whether appropriate notification were documented in the resident's medical records. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns.	

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F 580	Continued From page 3 NJ ex order 26.4b1 [redacted] During an interview on 09/17/23 at 1:00 PM, R224's Family Member (1) stated that she was not aware of the NJ ex order 26.4b1 on the resident's [redacted]. Review of R224's "Progress Notes" and "Miscellaneous" tabs of the EMR revealed no documentation Family Member 1 was notified of the NJ ex order 26.4b1. During an interview with the [redacted] on [redacted] at 3:00 PM, she stated that they held an IDT meeting after R224 [redacted] on [redacted], and Family Member 1 was in attendance. She stated that she remembered discussing the NJ ex order 26.4b1 [redacted] with the family, but did not remember what meeting that was. After reviewing the IDT meeting notes, she confirmed that the note did not include documentation of the NJ ex order 26.4b1 [redacted].	F 580		
F 610 SS=D	NJAC 8:39-13.1(c) Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		11/8/24

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F 610	Continued From page 4 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and policy review, the facility failed to conduct a thorough investigation of an NJ ex order 26.4b1 of NJ ex order 26.4b1 for one resident (R375) of four residents reviewed for NJ ex order 26 out of a total sample of 37 after the family stated the resident told them NJ ex order 26.4b1 , and the resident NJ ex order 26.4b1 This has the potential to affect all residents receiving care by staff who may put residents at risk for NJ Exec Order 2 during care. Findings include: Review of R375's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed R375 was admitted to the facility on NJ ex order 26.4b1 . R375, who required staff assistance for transfers, was NJ ex order 26.4b1 by staff at various times on the NJ ex order 26.4b1 of NJ ex order 26.4b1 prior to a NJ ex order 26.4b1 at 1:00 PM. After R375 returned from the appointment, he NJ ex order 26.4b1 and was NJ ex order 26.4b1 NJ ex order 26.4b1 . NJ ex order 26.4b1 , and R375 NJ ex order 26.4b1 to the	F 610	Element #1 Resident #R375 NJ ex order 26.4b1 NJ ex order 26 Element #2 All residents with incidents and/or reported allegations have the potential to be affected by the alleged deficient practice. Element #3 US FOIA (B) (6) re-inserviced all Licensed Nursing Staff on 9/23/2024, and ongoing, on the policy on conducting a thorough investigation for resident incidents and reported allegations. All completed investigations will be reviewed by the Licensed Nursing Home Administrator(LNHA)/Designee to ensure that all staff who had the opportunity to provide care and services to a resident will be interviewed and their statements taken and documented. Element #4	

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F 610	Continued From page 5 NJ ex order 26.4b1 On NJ ex order 26.4b1 family members reported to the facility that R375 told them NJ ex order 26.4b1 by staff before leaving for his 1:00 pm appointment on NJ ex order 26.4b1 Review of the Facility's Investigation, dated NJ ex order 26.4b1, revealed that there were no interviews with the physical therapy aides or other staff that assisted with NJ ex order 26.4b1 of NJ ex order 26.4b1 before NJ ex order 26.4b1 to his NJ ex order 26.4b1 to go to his appointment at 1 PM. The staff that assisted with these NJ ex order 26.4b1 were not identified. Staff only identified, interviewed, and obtained statements from the two US FOIA (B) (6) US FOIA (B) that assisted with the transfer prior to the resident leaving for his 1:00 PM appointment. Review of R375's Discharge "Minimum Data Set (MDS)" with an assessment reference date (ARD) of NJ ex order 26.4b1 revealed a "Brief Interview for Mental Status (BIMS)" score was not determined. During an interview on 09/19/24 at 11:56 AM, the US FOIA (B) (6) stated the former US FOIA (B) (6) completed the investigation but that she NJ Ex Order 26.4b1 now. She said she contacted her and was told she would need to talk with her supervisor before answering any questions. The US FOIA (B) (6) stated she felt like the NJ Ex Order 26.4b for R375 was likely the result of the NJ ex order 26.4b1, and she felt they did a thorough investigation. She stated she was unaware that all staff involved with NJ ex order 26.4b1 of NJ ex order 26.4b1 were not identified or interviewed. The US FOIA (B) (6) confirmed all staff that assisted with any NJ ex order 26.4b1 on NJ ex order 26.4b1 should have been interviewed. She said she was going to have to reread the NJ ex order 26.4b1	F 610	LNHA/Designee will review 5 completed investigations monthly x 6 months to ensure a thorough interview process and investigation is done. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns.	

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F 610	Continued From page 6 NJAC 8:39-9.4(f)	F 610		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section-	F 645		11/8/24

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F 645	Continued From page 7 (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that a Preadmission Screening and Resident Review (PASARR) [redacted] was completed accurately for two of three sampled residents (Resident (R) 108 and R79) reviewed for PASARRs out of a total sample	F 645	Element #1 Preadmission Screening and Resident Review for Resident (PASRR) for residents R108 and R79 were reviewed and revised by Social Worker Director on 9/20/2024.	

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F 645	Continued From page 8 of 45 residents. This had the potential to prevent or delay additional services to a resident that might qualify for a [NJ Ex Order 26] PASRR. Findings include: 1. Review of R108's "Admission Record," located in the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on [NJ ex order 26.4b1] with diagnoses including [NJ ex order 26.4b1] Review of R108's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab of the EMR and with an Assessment Reference Date (ARD) of [NJ ex order 26.4b1], revealed she scored [NJ ex] out of 15 on the "Brief Interview for Mental Status (BIMS)," which indicated R108 had [NJ ex order 26.4b1] [NJ ex order 26.4b1]. Further review revealed R108 had [NJ ex order 26.4b1] Review of R108's '[NJ ex order 26.4b1] [NJ ex order 26.4b1], or Related Condition (PASARR)," located under the "Resident Documents" tab in the EMR and dated and submitted on [NJ ex order 26.4b1], indicated [NJ ex order 26.4b1] During an interview on 09/19/24 at 10:42 AM, the [US FOIA (B) (6)] stated after a resident was admitted to the facility, they ensured the PASARR was completed. She stated they did not admit a resident without a PASARR. The [US FOIA (] stated she was the one who was responsible for reviewing the PASARRs to make sure they were	F 645	Inservice on the revised PASRR Policy & Procedure was given by the Licensed Nursing Home Administrator (LNHA) to the [US FOIA (b)(6)] on 9/20/2024. Element #2 All residents who are admitted with a PASRR have the potential to be affected by the alleged deficient practice. Element #3 A review of all resident PASRRs were completed by the Social Service Director on 9/23/2024 and no other issues were found. The PASRR Policy and Procedure was revised on 9/20/2024 to include a review by the Social Service Director/designee for completion and accuracy. Social Worker Director/designee will review each new PASRR, starting 9/20/2024 and ongoing. Any PASRR Reviewed with an issue will be referred back to the sending provider to ensure PASRR accuracy. Social Worker Director and will maintain a binder documenting the outcomes of the review. Element #4 The LNHA/Designee will review 4 PASRRs each month for 6 months accuracy and completion. Results will be reported to the Quality Assurance and Performance	

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F 645	Continued From page 9	F 645	Improvement Committee meeting to identify trends and concerns.	

completed accurately. She stated a former employee was the person who completed R108's PASARR [redacted] but agreed it should have been completed accurately. The [redacted] stated she would review the R108's PASARR and have it corrected.

During an interview on 09/19/24 at 11:56 AM, the [redacted] stated staff should be reviewing the PASARR [redacted] making sure it was correct and if it was not correct, staff needed to revise and correct it.

2. Review of R79's "Profile" tab of the EMR revealed R79 was admitted to the facility on [redacted] with diagnoses that included [redacted] .

Review of R79's quarterly "MDS," located under the "MDS" tab of the EMR and with an ARD of [redacted], revealed R79 had a "BIMS" score of [redacted] out of 15, which indicated R79 was [redacted]

Review of R79's" PASRR [redacted]," dated [redacted] and located under the "Misc" tab of the EMR, indicated a [redacted]. Further review of the PASRR revealed that in Section II, there was no response to the question related to [redacted]. It was recorded R79 had [redacted]

Review of R79's [redacted] "Progress Notes," dated [redacted] and located under the "Misc" tab of the EMR, revealed R79 was seen by the [redacted] for [redacted] The progress note revealed, ". . .

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F 645	Continued From page 10 resident with a history of NJ ex order 26.4b1 . . . Patient has a NJ ex order 26.4b1 at [hospital name withheld] NJ ex order 26.4b1 NJ ex order 26.4b1 During an interview on 09/17/24 at 4:00 PM, the US FOIA (b stated that residents come from the hospital or another facility with their PASARRs already completed. When asked to review R79's PASARR, the US FOIA (b acknowledged the PASARR was not complete. The US FOIA (b stated, "Unfortunately, the questions were not answered, so it is not a complete PASARR." During an interview on 09/19/24 at 10:43 AM, the US FOIA (b stated that no one had reviewed R79's PASARR. She stated it was the facility's responsibility to review the PASARRs to make sure they were correct. She stated, " [R79] should have had another PASARR completed." During an interview on 09/19/24 at 3:00 PM, the US FOIA (b)(6)) stated R79 had been in an NJ ex order 26.4b1 , but he was unsure of the specific dates.	F 645		
F 806 SS=D	NJAC 8:39-5.1(a) Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat	F 806		11/8/24

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F 806	Continued From page 11 food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide food that accommodated resident NJ Ex Order 26.4b for one of seven sampled residents (Resident (R) 81) reviewed for food concerns out of a total sample of 37. This failure had the potential to cause residents harm due to NJ Ex Order 26.4b1. Findings include: Review of R81's undated "Admission Record," located in R81's electronic medical record (EMR) under the profile tab, showed a facility admission date of NJ ex order 26.4b1 and a re-admission date of NJ ex order 26.4b1 with medical diagnoses that included NJ ex order 26.4b1 Review of R81's "Food Preferences," dated NJ ex order 26.4b1 revealed, NJ ex order 26.4b1 The form did not provide an entry for any type of NJ ex order NJ ex order 26.4b1 " Review of R81's Care Plan dated NJ ex order 26.4b1 reveals, "R81 NJ ex order 26.4b1 " Review of R81's annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of NJ ex order 26.4b1, revealed the facility assessed R81 to have a "Brief Interview for Mental Status (BIMS)" score of NJ ex out of 15, which indicated R81 NJ ex order 26.4b1. During an interview on 09/16/24 at 10:36 AM, R81 stated, "Last Friday NJ ex order 26.4b1 I was given NJ ex order 26.4b1. NJ ex order 26.4b1 "	F 806	Element #1 Resident R81 was re-assessed by the US FOIA (B) (6) on 9/19/2024 for any delayed NJ Exec Order 26.4b1 related to the NJ Exec Order 26.4b1 and none was noted. Element #2 All residents with food allergies, dislikes, food preferences and substitutes have the potential to be affected by the alleged deficient practice. Element #3 All dietary staff were re-inserviced by the Food Service Director/Designee on 9/23/2024 on the policy on Allergies, Preferences and Substitutes. On 9/21/2024, a visual cue stating "Verify" was added to the tray ticket and checker was assigned on the tray line to verify the accuracy of food placed on the tray for residents with allergies, food preferences and substitutes. Element #4 Food Service Director/Designee will check 5 random trays weekly x 6 months to monitor accuracy of tray line. Audit will be documented and any issues will be immediately corrected. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 12 During an interview on 09/19/24 at 5:00 PM, the US FOIA (B) (6) stated R81 had been NJ ex order 26.4b1, and NJ Ex ate some of it. The US FOIA (B) (6) stated NJ Ex was provided NJ ex order 26.4b1 and NJ ex order 26.4b1 but requested NJ ex order 26.4b1 The US FOIA (B) (6) stated R81 NJ ex order 26.4b1 . During an interview on 09/19/24 at 5:15 PM, US FOIA (B) (6) 1 stated, "[R81] NJ ex order 26.4b1 . I checked the tray, and NJ Ex NJ ex order 26.4b1 and NJ Ex had eaten some of it. I informed the US FO US FOIA (B) of the situation. The US FO NJ ex order 26.4b1 I for the resident. [R81] NJ ex order 26.4b1 NJ Ex NJ ex order 26.4b1 and NJ ex order 26.4b1 During an interview on 09/19/24 at 5:20 PM, the US FOIA (B) (6), "When I went to check NJ Ex lunch tray, [R81] had been NJ ex order 26.4b1 NJ ex order 26.4b1 . NJ Exec meal ticket identified a NJ ex order " The US FOI stated R81 NJ ex order 26.4b1 NJ ex order 26.4b1 NJ ex order 26.4b1 . The US FOIA stated, "Since the incident, NJ Ex meal ticket has been modified to verify the meal prior to serving. The meal ticket system automatically changes the meal due to NJ ex order 26 and dislikes." During an interview on 09/19/24 at 5:45 PM, the US FOIA (B) (6) stated, "We do not have a policy and procedure related to the accuracy of the plating of food and ensuring that the resident gets the proper meal."	F 806	identify trends and concerns.	

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	315310	A. BUILDING _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE JERSEY CITY, NJ 07307**

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F 806	Continued From page 13 On 09/19/24 at 6:05 PM, a review of R81's meal ticket, dated [NJ ex order 26.4b1], with the [US FOIA] for the noon meal revealed R81 [NJ ex order 26.4b1], and [NJ EX] should have been given the alternate meal consisting of stuffed shells, tomato sauce, mixed vegetables, dinner roll, ice cream, apple juice, whole milk, ginger ale, coffee, and a small, tossed salad. The [US FOIA] confirmed, "The meal ticket system worked as indicated by the alternate meal being identified. However, [R81] was served the incorrect meal." NJAC 8:39-17.4(c)(e)	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	C 09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were	S 560	Element #1 Staffing coordinator was re-inserviced by the Licensed Nursing Home Administrator (LNHA)/ Director of Nursing (DON) on 9/20/2024, on meeting ratios needed for Certified Nurse Aides every shift. Element #2 All the residents have the potential to be affected by the deficient CNA staffing at any given day or shift. Element #3 Staffing coordinator will notify DON/Designee of any ratios not met. The facility will continue to utilize staffing agencies to fill in the open slots. Likewise,	11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	C 09/19/2024

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S 560	Continued From page 1 effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. For the week of Complaint staffing from 10/02/2022 to 10/08/2022, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -10/08/22 had 14 CNAs for 131 residents on the day shift, required at least 16 CNAs. -10/08/22 had 7 total staff for 131 residents on the overnight shift, required at least 9 total staff. 2. For the week of Complaint staffing from 01/01/2023 to 01/07/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts as follows: -01/01/23 had 12 CNAs for 142 residents on the day shift, required at least 18 CNAs. -01/07/23 had 17 CNAs for 142 residents on the day shift, required at least 18 CNAs. 3. For the week of Complaint staffing from 02/05/2023 to 02/11/2023, the facility was	S 560	overtime and bonus incentives will continue to be offered to our current working staff. In-service done for nursing management on ration of CNA's to residents needed. The ratios will be 1 CNA to 8 residents for day shift, 1 CNA to 10 residents for evenings and 1 CNA to 14 residents for nights. Element #4 Staffing ratios will be monitored by DON/Designee weekly and will be initialed by reviewer. DON/Designee will document weekly x 6 months on whether was met or not met for all shifts. Review of weekly ratio will be documented and submitted to the Licensed Nursing Home Administrator to review. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	C 09/19/2024

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S 560	Continued From page 2 deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -02/05/23 had 12 CNAs for 141 residents on the day shift, required at least 18 CNAs. 4. For the week of Complaint staffing from 03/12/2023 to 03/18/2023, the facility was deficient in CNA staffing for residents on 3 of 7 day shifts as follows: -03/12/23 had 14 CNAs for 135 residents on the day shift, required at least 17 CNAs. -03/13/23 had 16 CNAs for 134 residents on the day shift, required at least 17 CNAs. -03/18/23 had 15 CNAs for 139 residents on the day shift, required at least 17 CNAs. 5. For the week of Complaint staffing from 04/16/2023 to 04/22/2023, the facility was deficient in CNA staffing for residents on 2 of 7 day shifts and deficient in total staff for residents on 1 of 7 overnight shifts as follows: -04/16/23 had 10 CNAs for 130 residents on the day shift, required at least 16 CNAs. -04/22/23 had 15 CNAs for 129 residents on the day shift, required at least 16 CNAs. -04/22/23 had 8 total staff for 129 residents on the overnight shift, required at least 9 total staff. 6. For the 3 weeks of Complaint staffing from 05/14/2023 to 06/03/2023, the facility was deficient in CNA staffing for residents on 6 of 21 day shifts as follows: -05/14/23 had 12 CNAs for 134 residents on the day shift, required at least 17 CNAs. -05/18/23 had 15 CNAs for 133 residents on the day shift, required at least 17 CNAs.	S 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060905	A. BUILDING: _____ B. WING _____	C 09/19/2024

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S 560	Continued From page 3 -05/19/23 had 12 CNAs for 133 residents on the day shift, required at least 17 CNAs. -05/21/23 had 16 CNAs for 133 residents on the day shift, required at least 17 CNAs. -05/26/23 had 14 CNAs for 130 residents on the day shift, required at least 16 CNAs. -05/28/23 had 13 CNAs for 130 residents on the day shift, required at least 16 CNAs. 7. For the week of Complaint staffing from 10/08/2023 to 10/14/2023, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: -10/08/23 had 15 CNAs for 131 residents on the day shift, required at least 16 CNAs. 8. For the week of Complaint staffing from 05/19/2024 to 05/25/2024, the facility was deficient in CNA staffing for residents on 1 of 7 day shifts as follows: - 05/19/24 had 14 CNAs for 133 residents on the day shift, required at least 17 CNAs. 9. For the 2 weeks of staffing prior to survey from 09/01/2024 to 09/14/2024, the facility was deficient in CNA staffing for residents on 3 of 14 day shifts as follows: -09/01/24 had 15 CNAs for 128 residents on the day shift, required at least 16 CNAs. -09/08/24 had 13 CNAs for 125 residents on the day shift, required at least 16 CNAs. -09/14/24 had 15 CNAs for 130 residents on the day shift, required at least 16 CNAs.	S 560		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315310 Y1	A. Building B. Wing Y2	11/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580	Correction	ID Prefix F0610	Correction	ID Prefix	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. #	Completed
LSC	11/08/2024	LSC	11/08/2024	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315310 Y1	A. Building B. Wing Y2	11/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0580	Correction	ID Prefix F0610	Correction	ID Prefix F0645	Correction
Reg. # 483.10(g)(14)(i)-(iv)(15)	Completed	Reg. # 483.12(c)(2)-(4)	Completed	Reg. # 483.20(k)(1)-(3)	Completed
LSC	11/08/2024	LSC	11/08/2024	LSC	11/08/2024
ID Prefix F0806	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(d)(4)(5)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/08/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
9/19/2024	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
060905 Y1	A. Building B. Wing Y2	11/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/08/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING **01** B. WING _____	**09/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE** **JERSEY CITY, NJ 07307**

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E 000	Initial Comments An Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health (NJDOH) on 09/17/24. The facility was found to be in noncompliance with 42 CFR 483.73.	E 000		
E 030 SS=F	Names and Contact Information CFR(s): 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following:	E 030		11/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 10/11/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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OPTIMA CARE HARBORVIEW	**178-198 OGDEN AVE** **JERSEY CITY, NJ 07307**

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E 030	Continued From page 1 (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following:	E 030		

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	315310	A. BUILDING **01** B. WING _____	**09/19/2024**

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E 030	Continued From page 2 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complied with Federal, State, and Local laws. The deficient practice had the potential to affect all staff and 128 residents. Findings include: A review of the facility's "Emergency Preparedness Plan" revealed the communication plan had not been updated since 2018 and did not reflect accurate contact information. The staff members and contact information in the plan did not match current employees' names and contact information for the US FOIA (B) (6) [redacted] During an interview on 9/17/24 at 4:30 PM, the	E 030	Element #1 The Licensed Nursing Home Administrator and the Maintenance Director reviewed and revised the Emergency Preparedness Plan to update the communication plan to reflect accurate contact information on 09/23/2024. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 The Licensed Nursing Home Administrator and the Maintenance Director will review and update the Emergency Preparedness Plan every two years from the last revision date of 09/23/2024.	

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E 030	Continued From page 3 US FOIA (b)(6) confirmed the facility was not able to locate an updated communication plan with correct contact information during the survey.	E 030	Element #4 The Licensed Nursing Home Administrator and the Maintenance Director will audit the elements of the Emergency Preparedness Plan to ensure accurate and updated information every quarter x 8 quarters. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by Healthcare Management Solutions, LLC on behalf of the New Jersey Department of Health, Health Facility Survey and Field Operations on 09/17/24 and the facility was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy. Optima Care Harborview is a five-story building that was built in the 1980's. It is composed of Type II construction. The facility is divided into 13 smoke compartments. The diesel generator powers 80% of the building. There is a complete automatic sprinkler system (wet) with an electric fire pump. The number of occupied beds was 128 out of 180.	K 000		
K 161 SS=F	Building Construction Type and Height CFR(s): NFPA 101	K 161		11/9/24

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K 161	Continued From page 4 Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5 Construction Type 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of	K 161		

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K 161	Continued From page 5 approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain their construction type as required by NFPA 101 Life Safety Code (2012 Edition), Section 19.1.6.1. This deficient practice had the potential to affect all 128 residents. Findings include: An observation on 09/17/24 at 9:48 AM revealed ceiling tiles at the covered parking area, located below Floors Two through Five, were missing. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the findings and revealed stated the ceiling tile was missing because of a recent tropical storm that passed through the area. NJAC 8:39-31.1(c), 31.2(e)	K 161	Element #1 The Licensed Nursing Home Administrator and the Maintenance Director reviewed and revised the policy on Maintaining Smoke and Fire Barriers on 09/23/2024. Scissor lift was ordered and arrival scheduled in order to facilitate replacement of exterior ceiling tiles. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 Ceiling tiles will be replaced monthly and as needed by the Maintenance Director/designee. Element #4 The Maintenance Director/designee will monitor exterior ceiling tiles under the overhang and use of scissor lift monthly x 6 months. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting at least quarterly to identify trends and concerns.	
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting	K 291		11/9/24

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K 291	Continued From page 6 Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to test emergency lighting in accordance with NFPA 101 (2012 Edition) Section 7.9. This deficient practice had the potential to affect all 128 residents who resided at the facility. Findings include: A record review revealed monthly testing of the emergency lighting system had not been conducted in the previous 18-months leading up to the survey. Documentation provided by the facility indicated that testing of the emergency lighting system was most recently conducted in February of 2023. During an interview on 09/17/24 at 5:30 PM, the US FOIA (B) (6) confirmed the facility did not have any documented evidence the emergency lighting system was tested monthly after February of 2023. NJAC 8:39-31.1(c), 31.2(e)	K 291	Element #1 The Licensed Nursing Home Administrator and the Maintenance Director reviewed and revised the policy on Monthly Testing of Emergency Lighting System on 09/23/2024. The Licensed Nursing Home Administrator re-educated the US FOIA (B) (6) on on Monthly Testing of Emergency Lighting System on 10/3/2024. Testing of Emergency Lighting System was completed by the Maintenance Director on 10/3/2024. A log was initiated. No issues were identified. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 A Monthly log will be completed by the Maintenance Director/designee x 12 months. Element #4 The Maintenance Director/designee will monitor the testing of emergency lighting system monthly x 12 months. Results will be reported to the Quality	

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K 291	Continued From page 7	K 291	Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by:	K 321		11/9/24

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K 321	Continued From page 8 Based on observation and interview, the facility failed to separate hazardous areas from other parts of the facility in accordance with NFPA 101 Life Safety Code (2012 Edition), Section 8.4. This deficient practice had the potential to affect 35 residents. Findings include: An observation on 09/17/24 at 9:45 AM revealed unsealed three-inch overcuts around conduit penetrations in the rated wall separating the diesel generator from the rest of the building. The unsealed penetrations were located above the door in the Fire Alarm Control Panel (FACP) Room. During an interview at the time of the observation, the US FOIA (B) (6) confirmed the findings and stated the facility was unaware of the unsealed penetrations. An observation on 09/17/24 at 10:59 AM revealed the door to the Soiled Linen Room, located in the corridor by Room 412, failed to close in the door frame and latch which left the Soiled Linen Room open to the corridor. During an interview at the time of the observations, the US FOIA (B) (6) confirmed the findings and revealed the facility was unaware the door closer was not functioning. An observation on 09/17/24 at 11:15 AM revealed the door to the Soiled Linen Room, located in the corridor by Room 312 failed to close in the door frame and latch which left the Soiled Linen Room open to the corridor.	K 321	Element #1 On 10/3/2024, the Maintenance Director used Hilti elastomeric firestop sealant to seal penetrations around conduit penetrations in rated wall separating diesel generator from the rest of building. On October 3, 2024, the Maintenance Director/designee repaired the latch to ensure that the door to the Soiled Linen Room, located in the corridor by Room 412, will close and latch in the door frame. On October 3, 2024, the Maintenance Director/designee repaired the latch to ensure that the door to the Soiled Linen Room, located in the corridor by Room 312, will close and latch in the door frame. On October 3, 2024, the Maintenance Director/designee repaired the door to the Storage Room by Rehab on the second floor. A self-closing device was installed to ensure that the door closes and latches to the frame. On October 3, 2024, the Maintenance Director/designee sealed five-inch overcut around a pipe penetration behind the washing machines in the Laundry Room. On October 2, 2024, the Licensed Nursing Home Administrator and the Maintenance Director reviewed and revised the policy on Hazardous Areas.	

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K 321	Continued From page 9 During an interview at the time of the observation, the US FOIA (B) (6) confirmed the findings and revealed the facility was unaware the door closer was not functioning. An observation on 09/17/24 at 11:33 AM revealed the door to the Storage Room by Rehab on the second floor did not have a self-closing device installed and did not close and latch in the frame. Combustible materials (boxes, paper products) were observed stored in the room, which exceeded 50 square feet in size. During an interview at the time of the observation, the US FOIA (B) (6) confirmed the findings and revealed the facility was unaware a door closer was not installed on the door. An observation on 09/17/24 at 11:35 AM of the Laundry Room revealed an unsealed five-inch overcut around a pipe penetration behind the washing machines. During an interview at the time of the observation, the US FOIA (B) (6) confirmed the finding and revealed the facility was unaware of the unsealed penetration. NJAC 8:39-31.1(c), 31.2(e)	K 321	On October 2, 2024, the Licensed Nursing Home Administrator in-serviced the US FOIA (B) (6) and staff on revised the policy on Hazardous Areas. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 The Maintenance Director/designee will audit the facility to ensure that hazardous areas are separated from other parts of the facility monthly x 12 months. The Maintenance Director/designee will audit the facility to ensure that door latching are functioning appropriately in the facility monthly x 12 months. Element #4 The Licensed Nursing Home Administrator/designee will audit 2 areas of possible penetrations monthly x 12 months. Any issues will be addressed immediately. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in	K 345		11/9/24

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K 345	Continued From page 10 accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 9.6.1.3. The deficient practice had the potential to affect all 128 residents. Findings include: A review of the facility's contractor's "Fire Alarm Inspection Testing and Maintenance Report," dated 12/22/23 and 06/20/23, revealed the following deficiencies: The pull station in the Kitchen needs to be remounted. The heat detector in the Kitchen by the dishwasher is damaged and needs to be replaced. The smoke detector on the Fourth Floor by Stair A has a missing head. Documentation that the deficiencies had been corrected was requested by the surveyor but not provided by the facility during the survey. An observation on 09/17/24 at 4:25 PM of the pull station in the Kitchen revealed it was not secured in the proper position and still needed to be	K 345	Element #1 On 9/27/2024, the Maintenance Director/designee remounted the pull station in the kitchen. On 9/27/2024, the Maintenance Director/designee replaced the heat detector by the dishwasher in the kitchen. On 9/27/2024, the Maintenance Director/designee replaced the smoke detector on the Fourth Floor by Stair A. On 9/27/2024, the Licensed Nursing Home Administrator and the Maintenance Director reviewed and revised the policy on Fire Alarm Testing. On 9/30/2024, the Licensed Nursing Home Administrator inserviced the Maintenance Department on the revised Fire Alarm Testing policy. Element #2 All the residents have the potential to be affected by the alleged deficient practice. Element #3 The Maintenance Director will review the Fire Alarm Testing Report monthly x 6	

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K 345	Continued From page 11 remounted. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the findings and stated the facility was not aware the deficiencies had not been corrected. According to the US FOIA (b)(6) the fire alarm company was scheduled to correct the deficiencies on Thursday, September 19, 2024. NJAC 8:39-31.1(c), 31.2(e) NFPA 72	K 345	months to monitor the completion of necessary tasks from the report. Any issues will be addressed immediately. Element #4 The Licensed Nursing Home Administrator will audit the Fire Alarm Testing Report monthly x 2 quarters to ensure compliance. The audit will be documented. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced	K 353		11/9/24

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K 353	Continued From page 12 by: Based on observation, record review, and interview, the facility failed to maintain the sprinkler system in accordance with NFPA 25 Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems (2011 Edition). This deficient practice had the potential to affect all 128 residents who resided at the facility. Findings include: A review of the facility's "Backflow Prevention Device Assembly Test Report Form," conducted by [Contracted Sprinkler Company] on 05/16/24, indicated the following deficiency: "Left out of service due to relief valve leaking. Device needs to be rebuilt." On 09/17/24 at 2:00 PM and 4:30 PM, documented evidence that the deficiency had been corrected was requested but was not provided by the facility. During an interview on 09/17/24 at 5:30 PM, the US FOIA (b)(6) confirmed the finding and stated the facility was unable to provide documentation the deficiency had been corrected. NJAC 8:39-31.1(c), 31.2(e) NFPA 25	K 353	Element #1 The Maintenance Director repaired the relief valve on 10/3/2024. Report was requested to show the repair. The Licensed Nursing Home Administrator reviewed and revised policy Sprinkler Systems policy and the need to obtain reports on 10/2/2024. The Licensed Nursing Home Administrator re-educated the Maintenance Staff and US FOIA (b)(6) on the Sprinkler Systems policy and the need to obtain reports on 10/2/2024. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 The Licensed Nursing Home Administrator will review the items on the Backflow Prevention Device Assembly Test Report Form to ensure its accuracy and items needed for repair are available. Reviews will be conducted monthly. Element #4 The Licensed Nursing Home Administrator/designee will audit all Sprinkler System paperwork to ensure sprinkler system is maintained according to current standards. Audits will be completed monthly x 12 months. Any issues will be addressed immediately. Results will be reported to the Quality	

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K 353	Continued From page 13	K 353	Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.	K 363		11/9/24

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K 363	Continued From page 14 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors closed and latched into the frame without impediment and were constructed to resist the passage of smoke in accordance with NFPA 101 (Life Safety Code) 2012 Edition, Section 19.3.6.3. The deficient practice had the potential to affect 43 residents. Findings include: An observation on 09/17/24 at 10:27 AM revealed the corridor door, located at the Clean Linen Storage Room on the fifth floor, failed to latch in the door frame. An observation on 09/17/24 at 11:14 AM revealed the corridor door at Room 306 failed to latch in the door frame. During an interview at the time of each observation, the US FOIA (B) (6) confirmed the findings and stated the facility was unaware the doors were not latching in the door frame. NJAC 8:39-31.2(e)	K 363	Element #1 On 10/3/2024, the Maintenance Director/designee fixed the latch on Clean Linen Storage Room on the fifth floor to ensure that the corridor door latches into the frame without impediment. On 10/3/2024, the Maintenance Director/designee fixed the latch on corridor door at Room 306 to ensure that the corridor door latches into the frame without impediment. Element #2 All the residents have the potential to be affected by the alleged deficient practice. Element #3 The Maintenance Director inservice all maintenance staff on 10/3/2024 to ensure that door inspections are done monthly. The Maintenance Director/designee will inspect door latches in the facility to ensure proper latching and proper closure of corridor doors monthly x 12 months. Results will be documented in audit log. Element #4 The Licensed Nursing Home Administrator/designee will audit log	

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K 363	Continued From page 15	K 363	monthly x 12 months. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure penetrations in smoke barriers were protected by a system or material capable of restricting the transfer of smoke and smoke barriers were continuous in accordance with NFPA 101 Life Safety Code (2012 Edition) Sections 8.5.6.1 and 8.5.6. 2. This deficient practice had the potential to affect all 128 residents. Findings include:	K 372	Element #1 On 9/23/2024, the Maintenance Director/Designee sealed the unsealed gaps and penetrations using Hilti elastomeric firestop sealant for the following areas: Smoke barrier located in the corridor by Room 506S Smoke barrier located in the corridor by Room 520 Smoke barrier located in the corridor by Room 404	11/9/24

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K 372	Continued From page 16 An observation on 09/17/24 at 10:18 AM of the smoke barrier located in the corridor by Room 506 revealed a two-inch by five-inch unsealed gap at the top of the wall above the ceiling at the metal deck. An observation on 09/17/24 at 10:36 AM of the smoke barrier located in the corridor by Room 520 revealed a two-inch unsealed gap along the top of the wall at the metal deck above the ceiling. An observation on 09/17/24 at 10:57 AM of the smoke barrier located in the corridor by Room 404 revealed a two-inch unsealed gap at the top pf the wall above the ceiling tile. An observation on 09/17/24 at 11:13 AM of the smoke barrier located in the corridor by Room 306 revealed a three-inch overcut at a conduit penetration and a two-inch gap along the top of the wall at the metal above the ceiling. An observation on 09/17/24 at 11:19 AM of the smoke barrier located in the corridor by Room 320 revealed a six-inch by eight-inch unsealed gap in the wall and a two-inch unsealed gap along the top of the wall above the ceiling. During an interview at the time of the observations, the US FOIA (B) (6) confirmed the unsealed gaps and penetrations. The US FOIA (B) (6) stated the facility was unaware of the unsealed gaps and penetrations in the smoke barriers. NJAC 8:39-31.1(c), 31.2(e)	K 372	Smoke barrier located in the corridor by Room 306 Smoke barrier located in the corridor by Room 320 Element #2 All the residents have the potential to be affected by the alleged deficient practice. Element #3 The Maintenance Director/designee will inspect and monitor penetrations in smoke barriers to ensure that they are protected by a system or material restricting the transfer of smoke and smoke barriers were in accordance with the current Life Safety Code. Inspection will be done monthly and documented in an Smoke Barrier Inspection Log. Issues will be immediately corrected. Element #4 The Licensed Nursing Home Administrator (LNHA)/Designee will audit 2 areas with possible smoke barrier penetration issues monthly x 6 months. Issues will be immediately corrected. Trends and patterns will be submitted to the Quality Assurance and Performance Improvement committee for compliance monitoring at least quarterly.	
K 531 SS=F	Elevators	K 531		11/9/24

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K 531	Continued From page 17 CFR(s): NFPA 101 Elevators 2012 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in ASME A17.1, Safety Code for Elevators and Escalators. Firefighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. All existing elevators, having a travel distance of 25 feet or more above or below the level that best serves the needs of emergency personnel for firefighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. (Includes firefighter's service Phase I key recall and smoke detector automatic recall, firefighter's service Phase II emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.) 19.5.3, 9.4.2, 9.4.3 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to document the elevator's monthly operation of Firefighter's Service required by NFPA 101 (2012) Section 9.4. The deficient practice had the potential to affect all 128 residents that resided at the facility. Findings include: A review of the facility's inspection, testing, and maintenance records for the elevators revealed the facility failed to document the monthly operation of the Firefighter's Service. This documentation was requested on 09/17/24 at 9:15 AM, 12:00 PM, and 4:30 PM but was not	K 531	Element #1 On 10/3/2024, the Licensed Nursing Home Administrator re-educated the US FOIA (b)(6) /designee on the need to ensure that the documentation for the elevator's monthly operation of Firefighter's Service is kept in an accessible location in the facility. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 The Licensed Nursing Home	

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K 531	Continued From page 18 provided by the facility during the survey. During an interview on 09/17/24 at 4:38 PM, the US FOIA (b)(6) confirmed the finding and revealed the facility was unable to locate any documented evidence. NJAC 8:39-31.1(c), 31.2(e)	K 531	Administrator in-serviced the Maintenance staff on 9/23/2024 on the documentation requirements for elevator testing, inspection and maintenance. Element #4 Monthly Firefighters' Service Log will be reviewed monthly x 12 months by the Maintenance Director/designee. Any issues will be immediately brought to the attention of the Licensed Nursing Home Administrator. Issues and trends will be identified and submitted to the Quality Assurance and Performance Improvement committee for compliance monitoring at least quarterly.	
K 741 SS=E	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe	K 741		11/9/24

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K 741	Continued From page 19 design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to meet the requirements for smoking areas as required by NFPA 101 Life Safety Code (2012 Edition) Section 19.7.4. This deficient practice had the potential to affect twelve residents who smoke at the facility. Findings include: An observation on 09/17/24 at 11:40 AM of the smoking area on the second floor revealed dozens of cigarette butts in a plastic dustpan. A metal can with a self-closing lid was not available to empty ashtrays into. Only island style ashtrays were provided. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and stated the facility was not aware that metal cans were required to dump cigarette butts into. A review of the facility's "Temporary Smoking Agreement during Covid 19" indicated that cigarettes were not to be thrown on the ground or over the balcony. NJAC 8:39-31.2(e), 31.6(e)	K 741	Element #1 On 9/27/2024, the Licensed Nursing Home Administrator reviewed and revised the policy on Temporary Smoking Agreement to include the use of metal dustpan and a metal can with a self-closing lid. The facility purchased metal dustpan and a metal can with a self-closing lid on 9/27/2024 and placed the items on the smoking area in the second floor. On 9/27/2024, the Licensed Nursing Home Administrator inserviced the Housekeeping and Recreation Staff to ensure that only metal dustpan and the metal can with self-closing lid will be available and used in the smoking area. Element #2 All the residents who smoke have the potential to be affected by the alleged deficient practice. Element #3 On 9/27/2024, the Licensed Nursing Home Administrator inserviced the Housekeeping and Recreation Staff to ensure that only metal dustpan and the	

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K 741	Continued From page 20	K 741	metal can with self-closing lid will be available and used in the smoking area. On 9/27/2024, the Recreation Director/designee inserviced all residents who smoke to ensure that they place cigarette butts on the metal can with self-closing lid. Element #4 The Licensed Nursing Home Administrator/designee will audit the smoking area 3 times weekly x 6 months to ensure the proper disposal of cigarette butts in the smoking area. The audit will be documented. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility	K 912	Element #1	11/9/24

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K 912	Continued From page 21 failed to maintain their power receptacles to have at least one listed grounding pole as required by NFPA 99, Section 6.3.2.2. The deficient practice had the potential to affect all 128 residents at the facility. Findings include: A review of the facility's "Electrical Inspection Report," conducted on 10/18/23 by [Contractor Name], revealed the following deficiencies: Commercial kitchen outlets need to be GFI. GFI on toaster in Kitchen show open Neutral / Blender outlet needs to be GFI. Outlets under angel tank in kitchen need to be GFI. Men's Locker Room has a switch cover missing The Laundry Room has three bad GFI's. The Staff Bathroom on the Fifth Floor has bad GFI. Third Floor has bad GFI's in the following rooms: 309, 318, 324, 236, 317, 324 (two bad GFI's), 317. Fourth Floor has bad GFI's in the following rooms: 400, 404, 406, 412, 416, 417, 413, 411, 424, 431. Fifth Floor has bad GFI's in the following rooms: 518, 516, 510, 517, 531 (outlets not working). Documentation that the deficiencies had been corrected was requested by the surveyor but was not provided by the facility during the survey. During an interview on 09/17/24 at 4:35 PM, the US FOIA (B) (6) stated the facility was unable to locate any documentation indicating the repairs had been made.	K 912	The Maintenance Director/Designee installed ground-fault circuit interrupters (GFCI) in multiple areas as specified in the Electrical Inspection Report. The areas corrected are: Commercial kitchen outlets on 10/3/2024; Toaster in kitchen, Neutral / Blender outlet on 10/3/2024; Outlets under angel tank in kitchen on 10/3/2024; Switch cover in men's Locker Room was corrected on 10/3/2024; Three GCFIs in the Laundry Room were corrected on 10/3/2024; The GFCI in the staff Bathroom on the Fifth Floor was corrected on 10/3/2024; The GFCI in third Floor in the following rooms: 309, 318, 324, 236, 317, 324, 317; The GFCI in fourth Floor in the following rooms: 400, 404, 406, 412, 416, 417, 413, 411, 424, 431; The GFCI in the Fifth Floor in the following rooms: 518, 516, 510, 517, 531. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 The Maintenance Director/designee will audit the facility to GFCIs in the facility maintains power receptacles x 12 months. Element #4 The Licensed Nursing Home Administrator/designee will audit 10 areas with GFCIs issues. Any issues will be addressed immediately.	

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K 912	Continued From page 22 NJAC 8:39-31.2(e) NFPA 70	K 912	Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power	K 918		11/9/24

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K 918	Continued From page 23 source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the generator in accordance with NFPA 110 Emergency Power and Standby Power Systems (2010 Edition), Section 8. This deficient practice had the potential to affect all 128 residents. Findings include: An observation on 09/17/24 at 3:30 PM of the facility's generator remote annunciator panel indicated "Low Water Temp" and "Call Powerhouse" alarms. During an interview on 09/17/24 at 3:30 PM, the US FOIA (B) (6) confirmed the findings and stated the facility was aware of the alarm and needed to contact the generator maintenance company to address the alarms. NJAC 8:39-31.2(e), 31.2(g) NFPA 99, 110	K 918	Element #1 "Low water temp" and "Call Powerhouse" alarms were addressed after the fuel was replaced on the tank on 10/8/2024, as supervised by the Maintenance Director. Generator service provider was able to reset alarms. The Licensed Nursing Home Administrator and the Maintenance Director reviewed and revised the policy on Generator System on 10/7/2024. The Licensed Nursing Home Administrator educated the US FOIA (b)(6) and staff on revised the policy on Generator System and responding to alarms on 10/8/2024. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 The Maintenance Director/designee will monitor generator alarms weekly x 12 months. Any issues will be addressed immediately. Element #4 The Licensed Nursing Home Administrator will audit the Generator	

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K 918	Continued From page 24	K 918	Alarm Log monthly x 12 months. Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		11/9/24

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 25 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to meet the oxygen storage requirements of NFPA 99 (2012 Edition), Chapter 11. This deficient practice had the potential to affect 22 residents. Findings include: An observation on 09/17/24 at 11:25 AM of the Corridor door to the Oxygen Storage Room at Rehab lacked the precautionary signage stating "CAUTION: OXIDIZING GASES STORED. NO SMOKING." Six E-cylinders were stored in a crate in the area. During an interview at the time of the observation, the US FOIA (b)(6) confirmed the finding and stated the facility was not aware that precautionary signage was missing from the door prior to the survey. NJAC 8:39-31.2(e) NFPA 99	K 923	Element #1 The Maintenance Director/designee placed a signage "CAUTION: OXIDIZING GASES STORED. NO SMOKING." on the corridor door to the Oxygen Storage Room at Rehab on 9/23/2024. The Licensed Nursing Home Administrator and the Maintenance Director reviewed and revised the policy on Oxygen Storage on 09/23/2024. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 All areas with Oxygen Storage in the facility have been inspected and all necessary signages are available. Maintenance Director/designee will monitor Oxygen Storage signages monthly x 12 months. Element #4 The Licensed Nursing Home Administrator will audit 3 areas of oxygen storage for appropriate signage monthly x 6 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315310	A. BUILDING **01** B. WING _____	**09/19/2024**

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K 923	Continued From page 26	K 923	Results will be reported to the Quality Assurance and Performance Improvement Committee meeting to identify trends and concerns at least quarterly.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315310 Y1	A. Building B. Wing Y2	11/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix E0030	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.73(c)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	11/08/2024	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315310 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	11/12/2024 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTIMA CARE HARBORVIEW	178-198 OGDEN AVE JERSEY CITY, NJ 07307

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0161	11/09/2024	LSC K0291	11/09/2024	LSC K0321	11/09/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0345	11/09/2024	LSC K0353	11/09/2024	LSC K0363	11/09/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0372	11/09/2024	LSC K0531	11/09/2024	LSC K0741	11/09/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0912	11/09/2024	LSC K0918	11/09/2024	LSC K0923	11/09/2024
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
9/19/2024	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO